Department of Health & Human Services Centers for Medicare & Medicaid Services 61 Forsyth St., Suite. 4T20 Atlanta, Georgia 30303-8909



August 13, 2008

Jack St. Clair, Director Cherry Hospital 201 Stevens Mill Road Goldsboro, NC 27530

RE: CMS Certification Number (CCN): 34-4003

Dear Mr. St. Clair:

Institutions accredited as hospitals by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are deemed to meet all of the Medicare Conditions of Participation for hospitals, with the exception of utilization review and the special staffing and medical record requirements for psychiatric hospitals. Section 1864 of the Social Security Act authorizes the Secretary of Health and Human Services to conduct surveys of accredited hospitals participating in the Medicare program if there are "substantial allegations" indicating serious deficiencies that could potentially affect the health and safety of patients.

A survey was conducted at Cherry Hospital on August 9, 2008, with immediate jeopardy being identified. A copy of the deficiencies cited during the August 9, 2008 survey is enclosed. Specifically, the facility does not meet the following conditions of participation:

42 CFR 482.12 Governing Body 42 CFR 482.13 Patients' Rights 42 CFR 482.23 Nursing Services

When a hospital, regardless of its JCAHO accreditation status, is found to be out of compliance with one or more Conditions of Participation, and immediate or serious threat to patient health and safety exists, a determination must be made that the facility no longer meets the requirements for participation as a provider of services in the Medicare program. Such a determination has been made in the case of Cherry Hospital and accordingly, the Medicare provider agreement between Cherry Hospital and the Secretary of the Department of Health and Human Services is being terminated. This termination will be effective September 1, 2008.

The Medicare program will not make payment for inpatient hospital services furnished to patients who are admitted on or after September 1, 2008. For patients admitted prior to September 1, 2008, payment may continue to be made for a maximum of 30 days for inpatient hospital services furnished on or after September 1, 2008. You should submit as soon as



possible, a list of names and Medicare claim numbers of beneficiaries in your hospital on September 1, 2008, to your fiscal intermediary to facilitate payment for these individuals.

We will publish a public notice in a local newspaper prior to the termination date. Termination can only be averted by correction of these deficiencies by September 1, 2008. Should we not hear from you, we will assume that the situation has not been corrected. If you believe that compliance has been achieved, you should notify CMS and the North Carolina State Survey Agency in writing on or before August 23, 2008, describing in detail the specific corrective measures taken to resolve these problems and include acceptable completion dates. An acceptable plan of correction must contain the following elements:

 The plan of correcting the specific deficiency cited. The plan should address the processes that lead to the deficiency cited;

2) The procedure for implementing the acceptable plan of correction for the specific

deficiency cited;

 The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;

4) The title of the person responsible for implementing the acceptable plan of correction.

If your "credible allegation" of compliance is accepted, the State Survey Agency will be authorized to conduct a resurvey to determine if the conditions which constituted immediate jeopardy have been removed and a full survey of all conditions of participation. Please be advised, however, that failure to remove conditions that constituted immediate jeopardy will result in your hospital's termination under Medicare, effective September 1, 2008. If the Centers for Medicare & Medicaid Services determines that the reasons for termination remain, the effective date of the termination remains September 1, 2008, and you will be so informed in writing. If corrections have been made, the termination procedures will be halted, and you will be notified in writing.

If you believe that this termination decision is incorrect, you may request a hearing before an Administrative Law Judge (ALJ) at the Departmental Appeals Board, Department of Health and Human Services. Procedures governing this process are set out in section 42 CFR 498.40, et seq. To be effective, a written request for a hearing must be filled not later than 60 days after the date you receive this letter. Such a request may be made to the following address:

Sandra M. Pace Associate Regional Administrator Centers for Medicare & Medicaid Services 61 Forsyth Street, SW, Suite 4T20 Atlanta, Georgia 30303-8909

We will forward your request to the Departmental Appeals Board. The request for a hearing should state why CMS's decision is considered incorrect, and should be accompanied by any evidence and arguments you may wish to bring to the attention of the Department of Health and

Human Services. Evidence and arguments may be presented at the hearing, and you may be represented by legal counsel.

If there are any questions, please contact Janetta Booker at (404) 562-7343.

Sincerely,

Sandra M. Pace

Associate Regional Administrator Division of Survey & Certification

Enclosure CMS 2567

ce:

JCAHO

State Agency

PRINTED: 08/19/2008 FORM APPROVED OMB NO. 0938-0391

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A 000	INITIAL COMMENTS		A	000				
		8/2008-08/09/2008 in order pital's compliance with the						
	Based on survey find was identified and was evidenced by the	lings, an immediate jeopardy as determined to be ongoing following:				e San Carlo		
	the U2 Building on	Patient #1 red under #1 choked						
. .	unlicensed personne 2020 and subsequer nurse (LPN) failed to	ration administered by If (HCT) on 04/28/2008 at Itly foli. The medication If respond to the emergency, patient after the incident and						
	failed to report the In registered nurse. The assess the patient, for the supervisor, delay	cident to the charge no charge nurse (RN) failed to giled to report the incident to yed reporting the chaking clan's assistant (PA) and						
	failed to report the fa down in a chair in the on 04/28/2008 at 22:	all to the PA. Patient #1 sat a dayroom (high traffic area) 25 after the fall and choking to patient remained in the						
	same chair for 22 ho patient was socied in four different shifts of	rurs and 34 minutes. The n the chair over a duaration of if care providers; evening night shift on 04/28/2008, day						
	shift on 04/29/2008 : 04/29/2008. Staff m	and evening shift on embers falled to follow or fluids and vital signs. Staff						
	assistance during the that the patient remains	nutrition and tolleting e 22 hours and 34 minutes ained in the chair in the					(XG) CATE	
LABORATORY	DIRECTOR'S OR PROVIDE	usupplier representative's signatu	京窓		TITLE		And the ser	

Any delicionsy statement anding with an autorisk (*) denotes a delicionsy which the inabitation may be excused from correcting providing it is determined that other safeguards provide authorism protection to the patients. (See instructions.) Except for norsing homes, the findings stated above are disclosuble 90 days following the date of survey weather or not a plan of correction is provided. For norsing homes, the above findings and plans of correction are disclosuble 14 days following the date these decements are made available to the facility. If delicination are cited, an approved plan of correction is requisite to continued program participation.

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	dayroom. Facility star was rendered care for resulted in petient negative for a staff interview revealed 4/28/2008 between CB a therapeutic approach behavior resulting in the patient on the right the bite. Interview with was acting out with usinteracting with the patient on the physician interaction with the patient of the event. Interview interacting with the patient of the event interaction we escalated the patient's interview revealed after approaches which could to de-escalate the patients staff injury as well as the physician. The investigation result incorporate to patients' his on 08/28/2008 at 0836. discussed with the edm 08/08/2008 at 1530. The systems in place to ensure care rendered to ensure care rendered to ensure care rendered to ensure care rendered to the start of the patients of the pa	if failed to ensure Patient #1 excess of 22 hours, which plect. patient #2 revealed an #2 ent of the U2 ent Ward of the U2 ent and 0840 failed to utilize to to redirect a patient's to physician being bitten by visician subsequently struck to shoulder blade to release to staff revealed the patient ual attention-seeking of 4/28/2008 and leading up to revealed staff were tient and had not requested tysician prior to the tith the patient, which behavior. Further staff that patient, which behavior. Further staff that behavior, preventing the patient being hit by the ed in an immediate that and safety beginning The findings were tinistrative staff on the facility failed to have the patients received and noglect of patients and the war accurately	A 0				
	documented. The IJ wo 482.12 GOVERNING B		A 043	\$			

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		to ensure Patient #1 was						

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7	investigation for an alk	e patient's guardian of an egation of physical abuse of If for 1013 sempled records					
	~cross refer to 482.13(Tag A0122	a)(2)(ii) Patients' Rights					
	D) The hospital's nurs supervise and monitor assure basic needs (to hydration) were provide records (#1).	ileling, autrition and					
	~cross refer to 482.23(A0395	b)(3) Nursing Services Tag					
	as evidenced by falling	ovided to prevent neglect to provide supervision, nal needs and hydration for					

OTATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA AND PLAY OF CORRECTION (DENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	staff." Credential file review hand-delivered letter of the Physician Clinical Threefigatory Placem Physician A. Further discussion on April 29 with the Administrative you are being placed with pay effective imminvestigation should ladaysCuring this perinot return to the job si authorizationYou are badge, and pager whit possession until the in Review of time sheets the physicians usual divided was on administrative \$711/2008, was on vactorization with the Physician A Interview with the Physician A Interview revealed the patient by physician A Interview revealed the restricted the physician hospital while the Investigation of physician a physician of physical a physician was substantilegation of physical aphysician was substantilegation of physical aphysical aphy	for Physician A revealed a fated April 30, 2008 from Director regarding ent with Pay" addressed to review revealed "As per our , 2008, and to accordance a Policy Manual, section II, on investigatory placement ediately. This period of st no longer than thirty (30) and of investigation, you may be without my prior a to turn over your keys, ID ch will remain in my vestigation is complete." for physician A revealed ay off was 4/30/2008 through sation 5/12/2008 through sation 5/12/2008 through called the physician was release effective agaiten of abuse towards a was being investigated, administrative teave a from practicing at the stigation was ongoing and or authorized the physician view confirmed the buse of a patient by the listed by the hospital's dent. Further interview was given work	A 043			

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A 122	procedures, investigation for an investigation for ebuse of a patient by sampled records (#2) Findings include: Review of facility politically politically dated 02/Notifications Required Social Worker shall in responsible person/or allegation of abuse, and pending investigation of abuse, and pending investigation of the mand/or Exploitation in #1964 initialed 4/28/2 being hit on the back "Immediate telephone made to the following staff member) - Date called - 3:05p.m" Record review for patient #29 mother we patient #29 mother we patient #29 mother we patient. Review of a A on 4/29/2008 at 08-take the undershirt he al patients and staff. down and bit this MD	cy children of physical facility staff for 1 of 3 cy cy challed for 1 of 3 cy children of Patients, 18/2008 revealed "H. of 18/2008 revealed for exploitation will be edical record." cocacy "Abuse, Neglect verification Report" for case 18/2008 and involving patient #2 by Physician A revealed of called - 4/28/2008, Time 18/2 revealed an 18/2 revealed "Attempted to	A 12	2		

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	~cross refer to 482.13 A0145	(c)(3) Patients' Rights Tag					
	patient with mental like by failing to implement order to prevent an ex-	lde a safe environment for a less and mental relardation I therapeutic measures in scalation in the patient's or 1 of 3 sampled records					
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A 122	Tag A0122 482.13(a)(2)(ii) PATIE	(a)(2)(ii) Patients' Rights NT RIGHTS: GRIEVANCE	A 1	22			
	REVIEW TIME FRAM At a minimum: The grievance process for review of the grieva response.	ES s must specify time frames ance and the provision of a			•		
		•				·	
	This STANDARD is n Based on review of fac	ot mot as evidenced by: tility policies and					

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him & let him distoring progress notes on 4/2 A revealed "Mother in revealed no other ent the mother being notified abuse and pending in abuse and pending in Interview with Patient at 1140 revealed the investigation for case case #1984 involved abuse of patient #2 by revealed the social with notifying the guardian physical abuse allegation. Interview notified the responsibility the day of the incident interview revealed one completed the allegational patient by Physician A letter was sent to Patient was sent to Patient was sent to Patient the guardian calle unaware there was an abuse to her son (Patier the guardian calle unaware there was an abuse to her son (Patier that her son had bitten interview with SW #1 crevealed the social wo patient #2 on 4/28/200 SW was notified of the Advocate on 4/28/200 one of the nurses reponotified of the incident phone call to the guard	(R) shoulder blade, pushing this teeth" Review of 18/2008 at 1405 by physician olified of incident" Review ry in the record regarding fied of the allegation of vestigation. Advocate #1 on 8/08/2008 advocate completed the #1984. Interview revealed an allegation of physical replacement #2 of the item and the pending wrevealed the advocate as social worker (SVV #1) on (4/28/2008). Further the investigation was on of physical abuse of a was substantiated and a ant #2's guardian with the called that in a week or two and stated she was silegation of physical abuse of the five that in a week or two and stated she was allegation of physical abuse of the mast #2's guardian with the called that in a week or two and stated she was silegation of physical and \$400 physical and \$400 physical and \$400 physical and \$400 physical A. In 8/08/2008 at 1445 there was assigned to \$500 physical the \$500 physical and \$500 physical and \$700 physical a	A	22				

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A 122	Continued From pag	e 10	А	122			
A 144	was not notified of the physical abuse a revealed "I should be interview confirmed a upon initiation of the investigation. Interview policy on regulardian for any abuse 13(c)(2) PATIEN SETTING	itten Physician A and she e pending investigation of llegation. Further interview two called but I didn't", the mother was never notified physical abuse allegation two confirmed facility staff did tolification of a palient's use allegation investigation. IT RIGHTS: CARE IN SAFE	A	144	,		
	Based on review of a procedures, invostig interviews staff failed environment for a paramental relardation by therapeutic measure	ation reports and staff of to provide a safe attent with mental illness and y falling to implement as in order to provent an ient's aggressive behavior for					•
	Review of Clinical pointerventions (NCI)" "Purpose: NCI is de the patients in the le appropriate available prevent(ion)/alternatemanagement of agg	oticy "North Carolina dated 10-03-2006 revealed usigned to meet the needs of east restrictive therapoutically a setting. NCI teaches tives, do-escalation, and pressive behaviors through the measures and approved					

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***************************************	physical techniques." "(Name of facility) le of treatment, and rehabit humane, safe, and cashall continuously suridentify petients displayitation and potential directed towards self of the rapeutic communicatechniques immediate "Procedures utilized in shall be in accordance provisions: 1. Positive alternatives shall be of whenever possible priorestrictive interventions. Review of the "North C Prevention/Alternative 4/20/2002 revealed "Procedures of the "North C Prevention/Alternative intervention. Sometim best efforts, people's bescalate or worsen. E is to avoid and escalat confrontation. It is stall strategies almed at heistalm down. Always for grecefully back down or revealed "Monitoring yestif-check. If you recording might make the swalk away from it. This course, you must not of Further review revealed starts to do something should not be ignored, asking the person to do	Further review revealed ormulited to the care, litation of all patients in a ring environment Staff very the environment to ring evidence of increasing of dangerous behaviors or others and intervene with alion or other de-escalation by." Further review revealed in the implementation of NCI with the following and less restrictive considered and attempted or to the use of more s." Carotina Interventions work dated and A Unit 5 Early Crisis les, in spite of everyone's enhavior can begin to ven at this point, your goal from and to avoid a not too late to try some sping people cool off and ok for ways for everyone to or feave." Further review ourself - You can do a gnize that what you're stressful situation worse, s. Is difficult to learn, and, of ompromise safety." I "Re-direction - If a person hurtful or hamful that interrupt the behavior by		**************************************			

	OF DEFICIENCIES CORRECTION	(xt) providerosuppliericula identification number:	(X2) 68 A. BUS		LE CONSTRUCTION	(XI) DATE SURVEY COMPLETED	
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A 144	Continued Frâm page	12	A	144	**************************************		
4	progress note by Phy 0840 revealed "Attem he (patient #2) was since (L) (loft) arm. Unit with my free hand (R) shoulder blade, pushing teeth"	Review of a sician A on 4/28/2008 at pted to take the undershirt napping at patients and staff, ead down and bit this MD on fortunately, instinctively - (right) I popped pt in (R) ng him & let him dislodge Advocate #1 on 8/08/2008 advocate completed the			·		
	case #1984 involved abuse of patient #2 by substantiated at the cinvestigation. Intervise during the course of the patient in order to the bite. Interview rethe course of the investigation area after the revealed that interview investigation had with physician hit the paties struggle over the t-sh.	ow revealed that interviews he investigation physician admitted to hitting get the patient to release wealed that interviews during estigation found that the idened hand mark on the e event. Further interview wa during the course of the lesses who saw or heard tho ent on the back during the left.					
	revealed the HCT wa the morning of 4/28/2 HCT #1 had received	s interacting with Patient #2 008. Interview revealed				•	

CENTERS FOR MEDICARE & MEDICAID SERVICES					C)	MB NO. 0938-0391
STATEMENT	of Deficiencies Correction	(XI) PROVIDER/SUPPLIERCIA SIERTISCATION HUMBER:	(X7) ML A. BUIL	A TAPLE CONSTRUCTION OING	(X3) D	DIAMETED ATE SURVEY
·.		344003	5. WW	5. V2003		C 08/09/2008
NAME OF PR	OVIDER OR SUPPLIER		<u>-</u>			TOTO DI LOCO
	HOSPITAL			STREET ADDRESS, CHY, STATE, 2H 201 STEVENS WILL ROAD GOLDSBORO, NC 27530	*CODE	
(XA) (Ó PREFIX TAG	(EACH DEFICIENC)	ntément of dericiencies I must be preceded by Pull SC identifying importation)	PREFIX	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REPERENCED	i of Correction Action should be to the Appropriate Ency)	COMPLETION CATE
	Interview revealed parameres' station hitting and fiste and making at the training to get the test of the HCT arrived on shorevealed the HCT was in an attempt to get the test and attempt to get the test and attempt to get the test and the test and patient #2 did not have a grobbed the test and forth interview revealed Physician A grobbed the test and forth interview revealed Physician A on the arraying to control (Fawinging back and forth interview revealed "I didn't see was trying to control (Fawinging or the floor". In never asked for assisting on the floor". In the test asked for assisting the floor of the floor o	tient #2 was outside of the the window with his shoes a popping motion with his shoes in popping motion with his was revealed. This was his sever, he wanted to get latus." Interview revealed ing these behaviors since iff at 0700. Interview interacting with patient #2 a petient to hand over the apping it at others. Interview revealed that when the ew revealed that when it over the 1-shirt. Physician Further interview revealed an A then both began at the shirt. Further interview what happened after that - I retient #2's arm from A)." Further interview was the revealed the HCT ance from Physician A. It didn't take the shirt use I didn't take the shirt use I didn't have an order review revealed the patient's ated to a level which would intervention.	A 1			
	#2 at the beginning of t	he shift. Interview				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF AND PLAN OF CORRECTION IT IDENTIFICATION IT IN	MER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PROMOER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	***************************************		9/2098	
CHERRY HOSPITAL		Street address. City, State. 219 201 Stevens Mill Road Goldsboro, NC 27530	con		
(x4) id Summary Statement of Deficiencies Prefix (each deficiency must be preceded by 1 Tag regulatory or LSC identifying informa	FULL PARES	CROSS-REFERENCED TO	Provider's Plan of Correction (Each Corrective action Should 82 Cross-referenced to the appropriate Depiciency)		
A 144 Continued From page 14 revealed the patient was exhibiting his usual attention-seeking behavior that morning. Interview revealed the care team of nursing social workers and physicians were having patient conference meeting around 0830 or morning of 4/28/2008 in the nurses' station Interview revealed RN #1 noticed Patient #2 popping his t-shirt al staff just outside of the nurses' station. Further interview revealed got up to go and redirect Patient #2 and we asked by Physician A to sit down and "he swould take care of it." Interview revealed Physician A left the meeting and when he chack into the nurses' station, RN #1 heard Physician A state that he had hit the patient interview revealed "if I would have known to was going to happen (Physician A hitting P #2), I would have never sat back down." Finterview revealed "I was going to go cut at redirect (patient #2) to a different area to decrease his secondary gain and gratificati was getting from being disruptive." A 145 A 145 A 146 A 146 A 147 The patient has the right to be free from all of abuse or harassment. This STANDARD is not met as evidenced Based on policy review, closed record reviewing its video recording review and staff inte the facility staff failed to ensure Patient #1	siles s. s. s. s. s. s. s. s. s.	145			

NAME OF PROVIDER OR SUPPLIER CHERRY HOSPITAL. (KA) ID SUMMARY STATEMENT OF DEPICIENCIES (CDLOSBORO, NC. 27530) (KA) ID SUMMARY STATEMENT OF DEPICIENCIES (CACHOCPRECITIVE ACTION SHOULD PREFIX (EACHOEPTCIENCY MUST BE PRICEDED BY FULL PROPERTY (EACHOEPTCIENCY MUST BE PRICEDED BY FULL PROPERTY (EACHOEPTCIENCY OR ISC IDENTIFYING INFORMATION) A 145 Continued From page 15 (CROSS-REFERENCE) TO THE APPROPRIATE (CROSS-RE	(XI) DATE SURVEY COMPLETED	
CHERRY HOSPITAL (X4) ID SUMMARY STATEMENT OF DEFICIENCIES RECEIVED BY FULL PROFIT (EACH DEFICIENCY MUST BE PRICEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A 145 Continued From page 15 resulted in patient neglect for 1 of 3 sampled records (#1). The findings include: Review of the "Abuse/Neglect/Exploitation of Patients, Prohibited" policy effective 02/19/2008 revealed neglect is defined as the failure to provide necessary care or services (medical or otherwise) to maintain the mental health, physical health and/or well-being of the patient. The policy revealed "Examples of shuse or neglect include.	G	
(X4) ID REFIX 16ACH DEPICIENCY MUST BE PRICEDED BY FULL. 16ACH DEPICIENCY MUST BE PRICEDED BY FULL. 16ACH DEPICIENCY MUST BE PRICEDED BY FULL. 16ACH CORRECTIVE ACTION SHOULD 16ACH DEPICIENCY) A 145 Continued From page 15 A 145 resulted in patient neglect for 1 of 3 sampled records (#1). The findings include: Review of the "Abuse/Neglect/Exploitation of Patients, Prohibited" policy effective 02/19/2008 revealed neglect is defined as the failure to provide necessary care or services (medical or otherwise) to maintain the mantal health, physical health and/or well-being of the patient. The policy revealed "Examples of shuse or neglect include.	08/09/2008	
resulted in patient neglect for 1 of 3 sampled records (#1). The findings include: Review of the "Abuse/Neglect/Exploitation of Patients, Prohibited" policy effective 02/19/2008 revealed neglect is defined as the failure to provide necessary care or services (medical or otherwise) to maintain the mental health, physical health and/or well-being of the patient. The policy revealed "Examples of shuse or neglect include.	DBE COMPL	Yaşıa 🗼
carry out orders for treatment (excluding medication variance process); 8. Feiture to cate for the patient's basic needs; 10. Faiture to provide a required level of supervision." Closed record review of Patient #1 reveated ####################################		

CENTERS FOR MEDICARE & MEDICAID SERVICES .				OMB NO. 0938-0391					
	of deficiencies Correction	ALCHROUGHRAUPPUERACLA . ISBMIRICATION NUMBER:	1	ULTEP: LOING	re construction	(X3) DATE SURV COMPLETE			
		344093	ß, Wis	rs		C 08/09/2008			
	ovixer or supplier Hospital			20	eet address, city, state, 21p code Di stevens mill road OLOSBORO, NC 27530				
(X4) ID Prefix Tag	(EACH DEFICIENC	atement of deficiencies Y must be pacceded by full LSC identifying information)	ID PRES TAX	XX	Providers Plan of Correct Each Corrective action shou Chois-Referenced to the Appro Deficiency)	.cee	CONPERION COMPERION DATE		
A 145	observation with vitate every 6 hours times 2 notes documented or 04/29/2008 at 0355. (patient was resting or remained on every 15 Precaution Flowshee 04/29/2008 revealed documentation of the behavior. Review of patient was focated in and calm or sleoping through 04/29/2008 at minutes); and documented of the found unresponsive a respirations at 2100. initiated and the paties another hospital whe at 2201. Further review of the admission orders dat 2201. Further review of the meal of the paties on 04/26/2008, the plunch and 1/3 dinner; breakfast, refused lut 4/28/2008 at a no breakfast, refused lut 4/28/2008 at a no breakfast, refused lut 4/28/2008 at a no breakfast. The reconsult was requested. The reconsult was requested.	signs and pulse oximetry 14 hours. Nursing and HCT 1 04/28/2008 at 2220 and 10444 and 1800 revealed the 1 interpretation of the state o	A	145					

		(XI) PROMOERISUPPLIERICLIA IDENTIFICATION NUMBER:	A. 808		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344003	B. VAN	3		C	
	ROYDER OR SUPPLIER HOSPITAL			2015	ADDRESS, CHY, STATE, ZIP CODE PTEVENS NELL ROAD DSBORO, NO. 27630	1 08/	09/2008
(X4) IO PREHX TAG	(CACH DEFICIENC)	ntement of depiciencies I must se preceded by full Scidentifying information	PREGI	x	PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION BROW OROSS-REPERENCED TO THE APPRO DEFICIENCY)	HO BE	(CX) (IO/TE/NOD TFAC
	Continued From page Further review of the pan order dated C4/28/1 fluids 8 oz (ounces) q times three days)." FOutput Record reveal on line top of the shee 8 oz every 2 hours time 04/28/2008 at 1522, e Further review of the son 04/28/2008 at 1522, e Further review of the review recentimeters) oral intake patient during the 150/04/29/2008. The review output was not docum. Further review of the patient received the hours as ordered. Received the patient review of the physician orders were not completely with a patient revealed a notation of the Vital Sig Sheet revealed a notation of the that stelled vital second	chysician's orders revealed 2008 at 1522 for "increase 2 hr x 3 days (every 2 hours deview of an intake and a statement handwritten that stated increase fluids es 3 days, started nding 05/01/2008 at 1522, theet revealed It was blank documentation of intake or vealed 900 cc (cibic e was consumed by the 0 through 2300 shift on an everaled the intake and conted for three shifts: ecord revealed the intake and conted for three shifts: ecord revealed no evidence e 8 ox of fluid every two cord review revealed no intake and ented for three shifts: ecord revealed that the sted. Differ revealed an order at 2220 for vital signs with hours times 24 hours. Insalveight/Glucose Flow ion at the top of the flow (eximetry) started	ļ		DEPICHENCY)	PRIMIE	CATE
**************************************	Review of the flow she order was received at 2 signs were documented 04/29/2008 at 0845 (8 i 891 vital signs complete patient refused on 04/2 effer prior vital signs co es completed on 04/29/	nours and 45 minutes after					

CENTER	S FOR MEDICARE & J	MEDICAID SERVICES				QMB NO.	0938-0391
отив <u>мент</u>	of deficiencies Correction	OT) PROMOGRASTAPPLIERCEIA IDEMTRICATION RUMBER:		Araba Araba	E CONSTRUCTION	(X3) DATE SUR COMPLETE	• [
		344603	. B. YAN	/G		C 08/09/2008	
NAME OF PR	omber or supplier			SYRE	eet address, city, state, zip code		
A1100000000	I A A A A A A A A A A A A A A A A A A A			20	1 STEVEKS MILL ROAD		1
CHERRY	105FI(AL			O(OLOSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencies Y Must be preceded by Full Lec Identifying information)	;D PREF TAG	XX	Providers Plan of Cossect (Each Corrective action show Cross-Referenced to the Appro Deficiency)	1005	COUPLETICIE DATE
A 145	Continued From page	o 18	A	145	•		
		x hours as ordered. The			·	1	
		ed no evidence the physician		,			İ
		signs were not monitored as		1			ļ
		he Medication Administration		1			1
		led pulse oximetry (ox) overy					Į
		rs from 04/28/2008 through lew revealed the pulse ox					
		00, 0600, 1200 and 1800.	1				
	L	the pulse ox was not					
		2008 at 1200. Review of the		}	·		
	ę ·	ocumentation why the pulse		1			
	ox was not complete						
	evidence the physicia	an was notified.					
	A dinital vidan rannoi	ling from the hospital's					
		ed 04/28/2008 through					
		owed. The video was					
		3 west on the U2 unit and					
	,	d time on 04/28/2008 at 2016					
	through 04/29/2008 :	at 2127. Review of the video					
	on 04/28/2008 at 20		1				
		dication to Patient #1. The					
		ationt choked after receiving			1		
		ell backward hitting his head					
		eo revesied HCT #2 was					ŀ
		al thrusts on the patient white reflect. The video revealed					
		ist the HCT during the					
		. The video revealed no	j				
		atient after the choking	}		1		Ę
		rther review of the video			<u></u>		ł
		was assisted by two HCTs					
	F	room at 2019. The video					
	revealed the patient	was standing in the dayroom					
		t2 took the patient's vital	-				
		rtched the cord from the vital					
	sign machine across		ļ		1		1
1		ting. The HCT hugged or					
	kissed another HCT	who was sitting at a table in					

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1	AV-V		1	~ · · · · · · · · · · · · · · · · · · ·			OMB N	<u>(O. 0936-0301</u>
	and pun o	of deficiencies I correction	(X1) PROVIDERSUPFLIERCHA IDENTIFICATION RUUSER:	(XX) ት ሊ ፀሀነ		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
1			344003	B. V40	۰		¢	
Ì	NAME OF R	ROMBER OR SUPPLIER		1	·····		. 08/	09/2008
Ì	1	MANUTA OU BOLLMEN				REET ADDRESS, CITY, STATE, ZIP COIXE		
1	CHERRY	Hospital	•		1	201 STEVENS INLI. ROAD		
ļ					. 9	GOLDSBORO, NC 27638		
ļ	(X4) (I) PRESIX	SUMMARY STA	TEMENT OF DEFICIENCIES	;D		PROVIDER'S PLAN OF CORRE	CTION	(49
ł	TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREA		(Each corrective action shi cross-referenced to the App		DEMONSTROM BEAG
Į.				1	•	OBJECTENCY)	WOLKSON SE	, vais
l	A 145	Continued From page	19		146			1
i			ards. The video revealed	, ^	140			
Ì		Patient #1 cal in a cha	if in the dayroom at 2225.			1		
١		The review revealed t	CT #1 provided the patient			1		
l		With a con of ilevid at	2238 and the patient was					
ļ	[observed to drink the	found through a plant was					1
ľ		Further toylow of the	ideo revealed the patient	}				1
		nence adt ai baalamen	chair in the day room until			1		
		04/29/2008 at 2059 /2	2 hours and 34 minutes).					1 1
]	Review of the video re	unalo and or managos.]
		offered to the nations of	iter 2238 on 04/28/2008	ì]
		while the nation remai	ined altting in the chair in	1		ŀ		
	1	the dayroom (21 hours	and 22 minutes without					
	[fluids). Review of the	patient's intake and output					į !
		record felled to reveal	documentation of this	ļ				1
		Intake on the Intake an	d output flow sheet. There	}	i			1 1
	!	is documentation on O	4/29/2008 that the patient					
	i	received 900 cc of suic	on the 1500 through 2300	1	1	'		
		shift. Video surveilland	e revealed that Petient #1] [
		did not receive any flui	ds during this shift. The	1	1			1
		video revealed that the	patient did not receive any	Ì	3			1
	1	fluids on the night shift	on 04/28/2008, day shift	1 .				
	ſ	on 04/29/2008 or even	ing shift on 04/29/2008.		1			1
	- 1	Further review of the vi	deo revoaled vital sions		1	•		1
	1	Were taken on 04/28/20	308 at 2222 by HCT #2.	}	1			ì
		Review of the record re	vested the vital signs	1	ĺ			
	1	loken at this time were	not documented in the		- 1			
	- 1	record. The video revio	ew revealed vital signs					
	1	were taken on 04/29/20	308 at 0847. Review of the			•		
	1	video revealed no furth	er vitel signs were taken	ĺ	- 1			
	1	while the patient remain	18d in the chair in the	1				
	Ì,	dayroom. Review of th	e record revealed the					
		patient refused vital sig	ns on 04/29/2008 at 1543,		- 1			
	1	Review of the video rev	ealed no effort was made	2	- 1			
	!	to take the patients vita	signs at 1643. Review of	ĺ	1		ļ	
	};	the record revealed the	patient's vital signs were		- [
] 1	documented as taken o	n 04/29/2008 at 1630.					
	11	Review of the video cor	firmed that the vital signs					
	1	were not taken on 04/25	9/2008 at 1630. Review of	Į	1			•
	1	he video revealed that	the patient's vital signs		ŀ		}	·
_				i	- 1			

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB N	OMB NO. 0938-0391	
STATEMENT (óf deficiencies Correctión	(X1) PROMOGRISUPPLIERICUA IDENTIFICATION NUMBER:	(X2) M A, B) UF		PLE CONSTRUCTION .	ONS DATE SURVEY COMPLETED		
		344003	B. Wie	10		08/09/2008		
NAME OF PR	OMDER OR SUPPLIER	 		97	reet address, city, state, zip code			
					201 STEVENS MILL ROAD		į	
CHERRY	HOSPITAL			GOLDSBORO, NC 27530			i	
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencies y must be preceded by fuel LSC (dentifying impormation)	ID PREF TAC	ЯX	Providents Plan of Corri Cach Corrective action st Cache Referenced to the Ap Deficiency)	KOULD BE	COPPLEASE COPPLEASE DVLG	
A 145	Continued From page	a 20	A	14	5			
	were taken two times	duling the 22 hours and 34						
		ant remained sitting in a chair	ļ					
	in the dayroom. Furt	hor review of the video					!	
	revealed the pulse or	imetry was not checked on	ì		1		}	
		vhich is consistent with the					1	
		w of the video revealed that						
		offer and encourage the						
		ist on 04/29/2008 and the						
		efuse. The video revealed						
		trays to the ward and allow						
		art unsupervised and allow					1	
		own trays. Further review of					[
		o staff member offered or ant to eat lunch or dinner on	1		-			
		of the video revealed the]					
		e food during the 22 hours						
		he remained in the chair in						
		view revealed on 04/29/2008					E .	
		op/oached the patient and					1	
		nt up from the front by						
		he HCTs were unsuccessful						
		After further ettempts, the						
		standing position. The						
		stable and one of the HCTs	1		· ·	•		
		nd towered the patient into	1		•			
		shows two HCTs sliding the	1					
	patient in the chair di	own the hall toward his						
	bedroom. The video	revealed the crash cart			·			
		e hallway at 2105. Further					1	
		evasled varying levels of staff						
		the dayroom during the 22						
		s the patient remained in the						
		. The review revealed HCT			1			
		dayroom for varying periods	1		1 .			
		vision throughout the night,						
		king on a cell phone,	1				•	
	somalimes in the pre						ļ	
		ideo revealed a HCT did not						
	enter the dayroom a	rea to check patients until						

Statement And Plan O	of deficiencies Francesion	(X3) PROVIDER/SUPPLIER/CHA (DENTIFICATION NUMBER:	(K2) X A. BUI		ие соняткистюн Э	COMPLETED	
		344003	9.498	۱G		C	
	Rowder or Eurplier Hospital		· · · · · · · · · · · · · · · · · · ·	STREET ADDRESS, CITY, STATE, 2IP CODE 291 STEVENS MILL ROAD GOLDSBORO, NC 27530		1 08/09/2008	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ac identifying information) There se preceded by full The identifying information	:D PREF: TAG		Promder's PLAN of Correcti (Each Corrective action skou) Cross-referenced to the Appro Deficiency)	DBE	OVIE CONNECTANA OVIE
	04/28/2008 at 0040 (1 shift started) and the il deyroom area until 01 after the shift started). Interview on 08/08/200 revealed she was the on 04/28/2008 when it nurse stated she was medication cart when was performing the life nurse stated "I watche request help. I got glo stood there and freake Heimilch maneuver no couldn't see well or tell fall. He got better. He I didn't assess him after (RN #2, the charge nurse port it to her. I waite later and reported it to She lold me to do an income up later. I clich't interview with the nurse stated it is the Rithat the orders after the PA saw the procurse stated it is the Rithat the orders are connot aware if the orders the med room." The in that LPN #1 did not attractived a report on mabout the patients from nurse further stated the the distribution of meal knowledge if patients wissues would be reported therview revealed LPN interview revealed LPN	hour and 40 minutes after ead tech did not enter the 13 (2 hours and 13 minutes 18 (2 hours and 13 minutes 18 (2 hours and 13 minutes 19 (2 hours and 13 minutes 19 (2 hours and 13 minutes 19 (2 hours and 14 hours and 14 hours after the patient chicked. The standing behind the the patient fell and HCT ff2 pirmich maneuver. The difference of the doil, I did not the was seen the foll over twenty years. I life was injured from the walked off with assistance, or the foil. I don't know how use) found out. I didn't do until I went downstates (the house supervisor). Incident report. (PA#8) talk with him." Further a revealed she had for vital signs and pulse ox attent on 04/28/2008. The N's responsibility to see ied out. She stelled "I was were carried out. I'm in terview further revealed end shift report and adication administration. The off going nurse. The at the lead HCT oversees trays and she had no were cating and that those end to the RN. The	A	4			

Statement of deficiencies (X1) Providensupplience (X1)		(X2) RGATIPLE A. BUNLDIMO	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		344003	8. WING		080	C 09/2008
	owder or supplier Hospital		201	t address, city, state, 21p code Stevens Mill Road LDSBORO, NG 27638		
eki) ID Prepix Tag	(EACH DEFICIENC	atembrt of deficiencies Y must be preceded by full LSC idepapying information	ID PREFIX TAG	Proynders Plan of Corf (Each Corrective action 8 Cross-references to the Af Deficiency)	NOOMO BY	COMPERTION COMPERTION DATE
A 145	the dayroom upon he interview revealed the had reported that the medications were be "I assumed the RN k his TB skin test at 18 was sleeping." Interview with HCT # member was not available was not available that she had revealed she was the 1500 - 2300 shift stated that she had retter #1 administered #1 on 04/20/2008. The HCT #1 administered #1 on 04/20/2008. The had reported the chot The nurse stated "S gotten him back to him. I didn't know I report. (The house stated "S gotten him back to him. I didn't know I don't remember if I the incident. I was not don't know if he was with (LPN #1) about interview revealed the house supervisor of fall. The interview revealed the PA and that the LPN orders. The nurse s	##1 sleeping in the chair in a rarrival to the ward. The a day shift medication nurse potient was seedated and ing held. The nurse stated new about his status. I read 00. He didn't talk to me. He 2 was attempted. The staff liable for interview. 208 at 1020 with RN #2 charge nurse on duty during on 04/28/2008. The nurse not been made aware that the medication to Patient he interview revealed that HCT #1 king to the charge nurse. He told me that she had a room. I didn't go check on seeded to do an incident supervisor) called me and fent report and notify (PA day in notifying the PA v I was supposed to call him. talked with (the PA) about of ewere the patient fell. I aware of the falt. I didn't talk what happened." Further is nurse did not notify the the choking incident or the two orders written by the two orders	A 146			

INTERS FOR MEDICARE & (MEDICAID SERVICES				<u> </u>	
TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(XI) PROMDERSUPPLIERCUA IDENTIFICATION NUMBER:	V BOM DING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	344003	B. WANG		ŧ	C 08/09/2008	
45 of provider or supplier Erry Hospital		21	CET ADDRESS, CITY, STATE, ZIP CODE DI STIEVENS MILL ROAD OLOSBORO, NC 27530	, 0010	31Z0UB	
ræfix (Each denciency	nement of deficiencies Thust be preceded by full SC Identifying information)	IO PREFIX TAG	Providers flan of Corre (Each Corrector action sh Cross-Referenced to The App Deficiency)	OULD BE	660 SETTE PRIORIES	
with him the entire shift she relied on staff to realing. PA #B was not availabt survey. Interview on 08/09/200 edministrative staff me staff member had revie as part of an investigative patient had died. It that the neglect was a member revealed that were not met and that tolleting, nutrition or hy and 34 minutes he was dayroom. The staff me of the video recording a documentation in the rewith the video and that that some of the documentation in the rewith the video review revealed Consequently, Patient receiving medication in personnel on 04/28/20 subsequently fell. The staff falled to respond the assess the patient after	g in the chair. I did not talk If." The nurse stated that sport if patients are not lie for Interview during the ereled from the video recording lithough the video recording lithous fall member revealed from the patient's basic needs he was not provided dration during the 22 hours as sitting in the chair in the limber revealed that review revealed that stelf lie cord was not consistent the investigation revealed nentation was falsified, aled that the investigation aled that the investigation aled that staff were not les and procedures. The at the nursing staff failed to although the palient's basic care 41 became choked after am an uniformed 08 at 2020 and medication nurse (LPN) o the emergency, failed to the incident and failed to e charge registered nurse.	A 144				

CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391						
STATEMENT (of deficiencies Correction	(X1) providerouppliericlia Identification number:	(X2) M A. BUI		LE CONSTRUCTION	(x3) date sur Complete	
		344903	B. 9///		·	ORIAG	; 1/2008
NAME OF PR	OVIDER OR SUPPLIER HOSPITAL	<u> </u>	·····	20	eet address. City. State, zip code Di stevens mill road Oldsboro, no. 27538	4000	72.000
(X4) IO PREFEX TAO	(BACH DEFICIENC	atement of deficiencies 7 must be preceded by full 5C identifying information)	ID PAREF YAG	1X	Providers plan of correcti (each corrective action shoul cross-referenced to the approx deficiency)	0.02	GO) GOMPLETION DATE
A 145	patient, failed to repo- supervisor, delayed in to the PA and failed to Patient #1 sat down in (high traffic area) on I fall and choking incide remained in the same minutes. The patient a duaration of four dif- providers: evening short Out/28/2008, day a evening shift on O4/28 failed to follow physics vital signs and failed nutrition during the 22 the patient remained Nursing staff failed to monitor the patient to 482.23 NURSING SE The hospital must hat service that provides	In the incident to the aporting the choking incident to report the fall to the PA. In a chair is the dayroom 04/28/2008 at 2225 after the ent at 2020. The patient is chair for 22 hours and 34 was seated in the chair over ferent shifts of care lift on 04/28/2008, night shift hift on 04/28/2008 and 8/2008. Staff members lan's orders for fluids and to offer tolketing, fluids and it hours and 34 minutes that in the chair in the dayroom. assess, supervise and prevent neglect. IRVICES		385			
	Based on closed reco recording review, pol- staff interview, the ho- organized nursing se to prevent neglect. To to assess, supervise	not met as evidenced by: ord review, digital video icy review, observation and espital failed to have an rvice as evidenced by failing he facility nursing staff failed and monitor the delivery of needs (toileting, nutrition and					

PRINTED: 08/13/2006 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (XI) PROVIDER/GLIPPLIST/OLIA CASH MULTIPLE CONSTRUCTION (X3) DATE BURVEY AND PLAN OF CORRECTION DEMORICATION NUMBER: COMPLETED A BUILDING B, WANG 344003 08/09/2008 NAME OF PROVIDER OR SUPPLIER BTREET ADDRESS, CITY, STAYE, ZIP CODE 201 STEVENS WILL ROAD CHERRY HOSPITAL GOLDSBORO, NC 27630 (X4) (D Summary Statement of Deficiencies PROVIDER'S PLAN OF CORRECTION स्ट्रायस्य १९६३ PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (RACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION Cross referenced to the appropriate TAG DATE DEFICIENCY A 385 Continued From page 25 A 385 hydration) were provided and failed to ensure medication was administered by licensed, vained staff for 1 of 3 sampled records (#1). The hospital's nursing staff falled to delegate and monitor patient care assignments to assure nutritional needs were met. The finding include: A) The hospital's nursing staff failed to assess. supervise and monitor the delivery of care to assure basic needs (tolleting, nutrition and hydretion) were provided for 1 of 3 sampled records (#1), ~cross refer to 482.23(b)(3) Nursing Services Tag A0395 B) The hospital's staff failed to ensure the delivery of care was provided to prevent neglect as evidenced by failing to provide supervision, tolleting needs, nutritional needs and hydration for 1 of 3 sampled records (#1). ~cross refer to 482.23(b) Nursing Services Tag A0392 C) The hospital's nursing staff failed to delegate and monitor patient care assignments to assure nutritional needs were met. ~cross refer to 482.23(b)(5) Nursing Services Tag A0397 The hospital failed to ensure medication was administered by licensed, trained staff for 1 of 3 sampled records (#1).

-cross refer to 482.23(c)(1) Nursing Services Tag

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0938-0391
		(CH) PROMOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	a burions			(x3) date survey completed	
		344003	6. W/8	ıĠ		C 08/08	2008
	CV/DER OR SUPPLIER HOSPITAL			25	eet address, city, state. ZIP code M Stevens Mill Road Oldsbord, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencies y must be preceded by full LSC Identifying information)	IO PREA TAS	ex .	Provider's Plan of Correct (Each Corrective Action Shous Cross referenced to the Appro Depiciency)	,686]	COS) COMPLETION CATE
A 385 A 392	The nursing service renumbers of licensed practical (vocational) to provide nursing eathers must be super each department or responses.	AND DELIVERY OF CARE must have adequate registered nurses, licensed nurses, and other personnel re to all patients as needed. visory and staff personnel for nursing unit to ensure, when to availability of a registered		385 392			
	Based on closed recording review and staff failed to ensure provided to prevent failing to provide sugnutational needs and records (#1). The findings include Closed record review Admits admits admits admits a patient choked a unlicensed personne 2020. Review of the	not met as evidenced by: ord review, digital video I staff interview, the hospital's the delivery of care was neglect as evidenced by servision, toileting needs, I hydration for 1 of 3 sampled or of Patient #1 revealed we of Patient #1 revealed the delivery of the record revealed fiter taking medication from the (HCT) on 04/28/2008 at record revealed a note by ssistant) dated 04/28/2008 at	, , , , , , , , , , , , , , , , , , ,				•

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STATEMENT AND PLAN O	of Deficiencies F Correction	(X1) PROVIDENSUPPLIER/CUA IOSNITIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE 6 COMPC	NO. OSSE-USSI EURVEÝ ETEO
		344903	A. (14) B. VIII				С
	rowder or supplier . Hospital		I	1	reet address, city, state, zip code 201 Stevens Mill Road Goldsboro, nc 27530	<u> 08</u>	/09/2008
(X4) ID PREFIX TAG	I (EACH DEFICIENC)	atement of depiciencies I must be diecoded by full SC identifying information)	ið PREF TAG	чx	PROVIDER'S PLAN OF CORRECT GEACH CORRECTIVE ACTION SHOUL CROSS RUFFERENCED TO THE AMPRIL DEFICIENCY	SLO BE	CONVENIENCES CONVENIENCES (NS)
**************************************	2200 (1 hour and 40 r that revealed that the the patient after a cho revealed an assessme PA. The notes documented on 04/28 documented on 04/28 documented on 04/28 o4/29/2008 at 0355. O patient was resting qui remained on every 15 Precaution Flowsheets 04/29/2008 revealed a documentation of the patient was located in the patient was located in through 04/29/2008 at minutes); and documented of the patient was located in the found unrespensive an respirations at 2100. Finitiated and the patient another hospital where at 2201.	ninutes after the incident) PA had been called to see king incident. The review ant was documented by the sented a plan of observation lise eximetry every 6 hours ng and HCT notes (2008 at 2220 and 444 and 1800 revested the felly without complaints and minute checks. Review of a dated 04/28/2008 through very 15 minute patient's location and the flowsheets revealed the the dayroom or bedroom om 04/28/2008 at 1800 2045 (26 hours and 45 notation at 2100 revealed of a late entry nursing note 155 revealed the patient bed around 2045 and was of without a pulse and testiscitative offorts were the was pronounced dead	A	392			
	admission orders dated 2200 calorle 3-4 gram s Review of the meal con on 04/26/2008, the pati unch and 1/3 dinner, o- preakfast, refused lunch W28/2008 ate no breakt	and ate 1/3 dinner; fast, 1/2 kunch and refused ale no breakfast, no lunch view of the record			P.S.		

	of deficiencies Correction	(X1) PROMOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILQING	CONSTRUCTION	(X3) DATE S COMPLI	
					ļ	c
		344903	B. WHG		08	/09/2098
NAME OF PR	OVIDER OR SUPPLIER HOSPITAL		201 8	i addreus, city, state, 2P cod Stevens Mal Road Osboro, NC 27630	Ę	
(X4) ID PAEFUX TAG	(EACH DEFICIE	Statement of deficiencies NCY Must be preceded by full Or LSC Identifying Information)	D PREFIX TAG	Promder's flan of c (each corrective activ Cross-Reperenced to th Deficiency) и оношьо вё Прирасорамие	(73) Domietkon Date
A 392	consume adequate or evaluated. The consult was requested physician was nutritional intake. Further review of the an order dated 04/fluids 8 ez (ouncestimes three days). Output Record review on the top of the signature on the top of the signature of the top of the signature of the top of the signature of the patient during the 04/29/2008. The coulput was not do Further review of the patient during the output was not do Further review of the patient receive hours as ordered, evidence the physician orders were not confidence that stated a sheet that stated a sheet that stated a sheet that stated a corder was receive order was receive order was received.	o nutritional intake was reported review revealed no nutritional ated and revealed no nutritional ated and revealed no evidence notified about the inadequate the physician's orders revealed (28/2008 at 1522 for "increase is) q 2 hr x 3 days (every 2 hours "Review of an Intake and realed a statement handwritten theat that stated increase fluids itimes 3 days, started 2, ending 05/01/2008 at 1522, the sheat revealed it was blank in no documentation of intake or w revealed 900 cc (cubic ntake was consumed by the 1500 through 2300 shift on review revealed the intake and cumented for three shifts, the record revealed no evidence and the 8 oz of fluid every two Record review revealed no evidence inciden was notified that the	A 392			
		15 (8 hours and 45 minutes after				

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O'TOTOTAL AND IN	OF OFFICE AND A	and the same of th	·······			OMB (NO. 0038-0391
AND FLAN OI	of deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) M A. \$U		TIPLE CONSTRUCTION US	(X3) DATE S COMPU	
		344003	8. WAN	VG_			C .
LILLE OF DE		374300				08	/09/2608
PANE OF IT	ROVIDER OR SUPPLIER			81	TREET ADORESS, CITY, STATE, 22P CODE		
CHERRY	HOSPITAL			ı	201 STEVENS MILL ROAD		
				_	GOLDSBORO, NC 27536		į
(X4) ID PRÉFIX TAG	(EACH DEPOSENC)	atement of deficiencies y mast be preceded by full SC :Dentifying diformation)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (BACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEPICIENCY)	4.08E	och Complession Date
A 392	Continued From page	29	Ι Δ	392	2		
	last vital signs comple		1 ^	031	4		f !
	patient refused on 04/	29/2008 at 1545 (7 hours			,		
	after prior vital signs of	completed) and documented	į į				
	as completed on Q4/2	9/2008 at 1630. The review	}		1		
	revealed the vital sign	6 were not assessed and					
,	documented every six	hours as ordered. The					
]	record review revealer	d no evidence the physician	1		1		1 1
	was notified that vite:	signs were not monitored as	Ì		-		
	ordered. Review of th	e Medication Administration					
	Record (MAR) reveale	ed pulse oximetry (ox) every					
1	o nours times 24 hoth:	s from 04/28/2008 through					
}	Odrabiation The 18416	w revealed the pulse ox	İ				
	The review revealed (0, 0600, 1200 and 1800,			1		
!	completed on 04130130	10 pulse ox was not 108 at 1200. Review of the]
:	Alexand to consulting	comentation why the pulsa					1 .1
1	ox was not completed	se ordered and as					
}	evidence the physician	was notified.					
	A digital video recordir	o from the hospital's					
1	security cameras date	d 04/28/2008 through					
1	04/29/2008 was review	red. The video was	ļ				
1	recorded from Ward 3	west on the U2 unit and	[1		1
i	reviewed as recorded	lime on 04/28/2008 at 2016					
	through 04/29/2008 at	2127. Review of the video					[
	revealed the patient fe	ll backward hitting his head			Í		
	on the floor after choking	ng on medication on	ŀ				
.	04/28/2008 at 2016. R	seview of the video					
1	revealed HCT #2 was p	penoming abdominal					1
1	nausis on the patient v	Atile the patient was on the filte video revealed the			1		
	patient was standing in	time video revealed the		,	1		
1	when HCT #2 took the	nationale with cions					1
	Heview revealed the 14	CT stretched the cord from]
	the vital stop machine	CT stretched the cold from across the room while she			1		1
1	appeared to be denoing	3. Further review revealed		i	Ì		
	the HCT hugged or kize	sed another HCT who was					
	citting of a lable in the	dayroom playing cards.					
	Review of the video rev	replied Patient #1 sat in a					1
				-] i

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO.	0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDENCUA- AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(K2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
		344003	8. γ./⊮	رة		08/09	/2008
паме об ря	OWDER OR SUPPLIER	***************************************		STR	eet address, chy, state, 20p coog		
***********					OI STEVENS MILL ROAD		
CHERRY	HOSPITAL			G	OLDSBORO, NO 27630		
(X4) ID PMEFIX YAG	(EACH DEFICIENC	atement of Deficiencies y aust be preceded by fire LSC Identifyixic information)	OI PRES TAI	tx :	Provider's Plan of Correct (Each Corrective action shou . Cross-referenced to the appro Defriency)	1005	oci) Completion Date
A 392	Conlinued From page	9 30	A	392			
	chair in the dayroom	at 2225. The review					1
	revealed HCT #1 pro	vided the patient with a cup					
	ol liquid at 2238 and	the patient was observed to					
		th a straw. Further review of					
		e patient remained in the					1
		room until 04/29/2008 at				1	1
		34 minutes). Review of the	1			ŀ	1
		ids were offered to the	1		1	[
		04/28/2008 while the patient					
		e chair in the dayroom (21 s without fluids). Review of					
		nd output record failed to				Į.	
	<u> </u>	no departeceso raiso to n of this intake on the intake					
		t. There is documentation					
		na patient received 900 cc of					
		ough 2300 shift. Video					
		I that Patient #1 did not	-		1 .		
	L ·	ring this shift. The video	1			-	
		iont did not receive any fluids					
		04/28/2008, day shift on					
		ng shift on 04/29/2008.					
		video revealed vital signs					
	were taken on 04/28	/2008 at 2222 by HCT #2.					
		revealed the vital algos					
	•	re not documented in the					
		view revealed vital signs			1		
		/2008 at 0847. Review of the	1			j	
		rther vital signs were taken					:
		ained in the chair in the					
		the record revealed the			·		
		signs on 04/29/2008 at 1543.					
		revealed no effort was made rital signs at 1543. Review of			1		
		the patient's vital aigns were			1	1]
		n on 04/29/2008 at 1630.	Į.				
		confirmed that the vital algas	1				
Í	1	1/29/2008 at 1630. Review of	1				
		not the patient's vital signs					
		s during the 22 hours and 34					
	1		l l				1

STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDERISUPPLIERICUA PENTINGATION NUMBER:	(X2) (A		PLE CONSTRUCTION 3	(XS) DATE SC COMPLE	
	344003	8, WM	۱¢		۸۰,	C 9/2008
NAME OF PROMOER OR SUPPLIER	······································		STR	RESTADDRESS, COLY, STATE, 2019 CODE	00/1	972098
CHERRY HOSPITAL			3	01 Stevens Will Road Soldsboro, NC 27630		
PREFIX (EACH DEFICIENC)	At Ement of Deficiencies I must be preceded by full SC identifying information)	ID Pres Tag		Provider B Flan of Correcti (Each Corrective action shold cross-referenced to the appro- deficiency)	DRE	EXS ECKTS, PFING JEENG JEENG
in the dayroom. Furth revealed the pulse on 04/29/2008 at 1200 wirecord review. Review a HCT attempted to or patient to eat breakfast patient appeared to rethat HCTs bring food the trays to sit on a capatients to get their over the video revealed no encouraged the patient of did not receive and 34 minutes that he dayroom. The revited to pull the patient holding his hands. The after two attempts. After two attempts. After two attempts. After two attempts, and patient was lifted to a spatient was lifted to a spatient in the chair over and the chair. The video significant in the chair down the invited of the video reventening and exiting the hours and 34 minutes that in the dayroom, staff remained in the did of time, watching televity playing cards and talking cometimes in the presse Observation on the videon are the dayroom are:	In remained sitting in a cheir review of the video of the video imetry was not checked on hich is consistent with the volume of the video revealed that lifer and encourage the ston 04/29/2008 and the finee. The video revealed rays to the ward and allow on trays. Further review of staff member offered or at to eat funch or clinner on at the video revealed the food during the 22 hours are remained in the chair in liew revealed on 04/29/2008 reached the patient and up from the front by at HCTs were unsuccessful for further attempts, the elanding position. The liewered the patient into hows two HCTs stiding the win the half toward his evealed the crash cart hallway at 2105. Further enled varying levels of staff a dayroom during the 22 the patient remained in the life review revealed HCT entroom for varying periods sion throughout the night, and on a cell phone, ence of the RN.		39			

CENTERS FOR MEDICARE & MEDICAID SERVICES

	of deficiencies Correction	(X1) PROVIDENSUPPLIENCELY DENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SUR COMPLETE	10	
		344003	B. WN6		08/09) 1/2088	
NAME OF PROVIDER OR SUPPLIER CHERRY HOSPITAL		I	STREET ADDRESS, CHY, STATE, ZIP CODE 201 STEVENS MILL ROAD GOLDSBORO, NC 27530				
(X4) 1D PREFIX TAG	(EACH DEPICIENC	atement of deficiencies Y Must be preceded by full LSG identifying information)	ID PREFIX TAG	Provider's Plan of Correction Sko (Each Corrective action Sko Cross-Heferenced to the Appr Deficiency)	fift RE	(XS) COCFLITON OATI	
	dayroom area until 0 after the shift started interview on 08/09/20 administrative staff member had reviae part of an investig the patient had died, that the neglect was member revealed the toileting, nutrition or and 34 minutes he wilded the video recording documentation in the with the video and the that some of the doc The staff member related video review revioltowing hospital pointerview confirmed provide ongoing evaluations. 482.23(b)(3) RN SUICARE	lead tech did not enter the 113 (2 hours and 13 minutes). 208 at 1350 with an namber revealed that the viewed the video recording ration of abuse/neglect after. The staff member revealed substantiated. The staff at the patient's basic needs at he was not provided hydration during the 22 hours as sitting in the chair in the member revealed that review grevealed that staff a record was not consistent at the investigation revealed unrentation was falsified, welled that the investigation revealed that the norsing staff failed to licies and procedures. The that the nursing staff failed to leation, monitoring and set the patient's basic care.	A 395				
	Based on policy ravi	not met as evidenced by: ew, closed record review, ng review and staff interview,					

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROMOERISUPPLIERCUA IOSHTIRCATION MUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		344803	B. V/01	۱G		C		
	ROWDER OR SUPPLIER HOSPITAL			,	reet address, chy, state, zip code 801 stevens mill road Goldsboro, no 27530	1 08/	09/2008	
(X4)10 PREFIX TAG	I (EACH DEFICIENC)	atement of dipiciencies 4 yost se precedio by full SC deutifying dipormation)	ID PREF TAG	1X	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR DEFICIENCY)	UQD \$E	OSS COMPLETION CASE	
	Continued From page the hospital's nursing supervise and monito assure basic needs (I hydration) were proving records (#1). The findings include: Review of the "Meets offective March 2004 provided with adequal part a regular schedule RN (registered nurse) to the dietician is imple personnel shall monito needs, record food into lose/gain Food and observed and docume flow sheet by nursing it meetined by a nursing foreported to the charge Closed record review of administration record (I medications were admit 2000 by LPN #1 (licens Review of a nursing no 04/28/2008 at 2020 docume Review of a nursing	staff failed to assess, the delivery of care to olieting, nutrition and led for 1 of 3 sampled and Nourishment" policy revealed "All clients will be a meals and nourishments and in a sessess and/or a referral amented Nursing or patients' nutritional ake and report weight fluid intake shall be need on the multi-purpose personnel at each and mealth and the nurse." If Patient #1 revealed a nurse." If Patient #1 revealed a nurse." If Patient #1 revealed a nurse." If Patient #1 revealed a nurse." If Patient #1 revealed a nurse." If Patient #1 revealed a nurse.	395	DEFICIENCY)	OPPRATE			
	was able to stand up ar ced. Pt. was breathing of the record revealed a	meds and started server was used and at of interview room. Pt, and walk with assistance to without difficulty." Review a note by PA #B (Physician 2008 at 2200 (1 hour and	**************************************					

CENTER	S FOR MEDICARE &	MEDICAID SERVICES	OM8 NO. 093				
	OF DEFICIENCIES CORRECTION	(X) provjersuppleracia Sebnurautanias	1, ,	ULTIPE LDING	le construction	COMPLETED	
			ļ			C	
		344003	B. WING			08/09/2008	
NAME OF PR	omder or supplier				EET ADDRESO, CITY, STATE, ZIP CODE DI STEVENS MILL ROAD		
CHERRY I	HOSPITAL		GOLOSBORO, NC 27630				
(X4) ID Priefix Yag	(EACH DEFICIENC	atement of deficiencies Y must be preceded by full SC (Definity) (NFORKATION)	PRES TAC	7X	Provider's Plan of Correct (Each Corrective Action Shoul Cross-Reperenced to the Appro Deficiency)	DBE	(A) Constition Date
A 396	40 minutes after the Ithe PA had been call; the PA had been call; choking incident. The denied breathing prolichest pain or palpital; without problems. Virus temperature 96 de respirations 20, pulse and pulse eximetry 9 a plan of observation eximetry every 6 hours on 04/28/2008 remained on every 11 continue to monitor. (HCT) notes on 04/28/2008 remained on every 11 continue to monitor. (HCT) notes on 04/28/2008 remained on every 11 continue to monitor. (HCT) notes on 04/28/2008 remained at 0920 revealed (medication) level was arrival without distress note at 0920 revealed (medication) level was discontinued the med s'probably second along pili. Will discontinued the patical day. Did answer to sleep. Continues stabilizer in his syste documented the patical day. Did answer to sleep. Continues chacks. VSS (vital si monitor and docume note on 04/29/2008 received a page of C and responded. Har (physician) at (anoth	ncklent) that revealed that and to see the patient after a mote revealed the patient of the pati	· A	395			
	department) of patier	ar nospital emargeticy nt in cardiopulmonary arrost I via EMS (ambulanca) to					

AND PLAN O	оf Defoiencies F Correction	(X1) PROVIDERUSI/PPLERACLIA IDENTIFICATION INLINGER:	1	(X2) MULTIPLE CONSTRUCTION A. GUILDING		CORPLETED (x3) DATE SURVEY COMPLETED	
		344003	a, wan	G		C .	
	rovider or supplier Mospital			20	ESTADDRESS, CITY, STATE, 2:P CODE 1 STEVENS MILL ROAD DLOSBORG, NC 27536	08/	09/2008
(X4) ID PRÉFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEPICHENCIES Y MUST HE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREFII TAG	T	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSH-RIFFERENCED TO THE APPRO- DEFICIENCY)	980	GAS COMPLETACIO DATE
	PA note at 2135 rever the Code Blue that was documented that staff was assisted to bed a was checked, the patisolied himself and was a physician's note at 2 received a calf from the department that the patist 2201, Review of a 2255 documented the at 2205. "Pt steeping 1900. When pt checked urinated on himself and breathing or pulse note measures) started. Coresponse) called and if Further review of the madmission orders dated 2200 calone 3-4 gram Review of the meal con on 04/28/2008, the patitunch and 1/3 dinner; of obreakfast, refused lunch and 1/3 dinner; of obreakfast, refused lunch and refused dinner. Rerevealed no evidence the evaluated the patient's review revealed no nutritudal intake. Further review of the ptending and refused and revealed and revealed and revealed and revealed physician was notified and utilitional intake.	department)." Review of a called the PA responded to as called at 2105. The note reported that the patient round 2045 and when he ent was found to have surresponsive. Review of 1210 documented he had de hospital emergency estent was pronounced dead falle entry nursing note at patient was assisted to bed in chair since I arrived at patient was assisted to bed in chair since I arrived at ed at 2100, patient had d was unresponsive. No ed. CPR (resuscitative bde Blue (emergency itMS contacted" second revealed physician's d 04/26/2006 at 0235 for a sodium diet (regular diet), neumption record revealed hand ate 1/3 dinner; clast, ¼ funch and refused it ate no breakfast, no lunch eview of the record he nursing staff had lack of nurrition. The ritional consult was to evidence the	A .	395			

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO.	0938-0391
STATEMENT (os beticiencies Correction	(X1) Providersuppuercua Identification number:	(X2) MG A. BUSL	-	6 CONSTRUCTION	(X3) DATE SUA COMPLETE	
		·	B. WHA		,	С	
		344003				08/69	/2008
NAME OF PR	OVIDER OR SUPPLIER		1	STRE	(et address, city, syate, zip code		1
CHERRY	HOSPITAL				1 Stevens Mill Road Olosboro, NC 27530		1
(xa) ID Prefix Tag	(BACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG		PROMISERS PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS REFERENCED TO THE APPRO DEFICIENCY)	380.	(CS) Completich Date
A 395	times three days)." R Output Record reveal on the top of the shee 8 oz every 2 hours lin 04/28/2008 at 1522, o Further review of the on 04/28/2008 with no output. The review re centimeters) oral Intal patient during the 150 04/29/2008. The rov output was not docum Further review of the the patient received to hours as ordered. Re evidence the physician's written on 04/28/2006 pulse oximetry every Review of the Vital S sheet revealed a not sheet that stated vital 24 hours and pulse o 04/28/2008 at 2224, o Review of the flow sh order was received a signs were document	teview of an Intake and led a statement handwritten at that stated increase fluids need 3 days, started anding 05/01/2008 at 1522, sheet revealed it was blank to documentation of intake or avealed 900 cc (oubic ke was consumed by the 00 through 2300 shift on item revealed the intake and needed for three shifts, record revealed no evidence the 8 oz of fluid every two accord review revealed no en was notified that the oleted. It order revealed an order at 2220 for vital aigns with 6 hours times 24 hours, gns/Weight/Glucose Flow ation at the top of the flow a signs every 6 hours times at (oximetry) started ands 04/29/2008 at 2224, lest revealed after the new to 2220 on 04/28/2008, vital led as completed on	A .	395	DEFICIENCY)		
	last vital signs compli- patient refused on 04 after prior vital signs as completed on 04% revealed the vital sign documented every si review revealed no e	8 hours and 45 minutes after eted), documented as 1/29/2008 at 1545 (7 hours completed) and documented 19/2008 at 1630. The review as were not assessed and x hours as ordered. The vidence the nursing staff was					
		l's vital signs as ordered after episode and fall at 2020 on					

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		MEDIOMO SELVANCES				OMBI	<u>O. 0938-0391</u>
AND PLAN O	OF DEFICIENCIES F CONRECTION	(X1) PROMDER/SLIPPLER/CLIA IDENTIFICATION NUMBER:	(X3) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		344003	(). WS	ets		08	C 09/2008
HAVAE OF PE	ROVADER OR SUPPLIER			T	100 100 100 100 100 100 100 100 100 100	***************************************	
CHERRY	HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 201 STEVENS MILL ROAD				
	2				COLDSBORO, NC 27530		Į.
(X4) ID PREFIX TAG	(EACH DEFICIENC)	atément of deficiencies I must be preceded by full SC identifying information	PRES TAG		Providers Plan of Correct (Each Corrective action shou Cross-referenced to the Appri Deficiency)	38 C.I	OXD COMPLETION DATE
A 395	Continued From page	37	١,	395		······	-
			1 "	999]
	VALCOLANDO. 118 18CC	or believe revealed no					1
	evicence ine physicia:	n was notified that vital					1
	signs were not monito	red as ordered. Review of					
	the Medication Admin	istration Record (MAR)					
	revealed pulse eximet	ry (ox) every 6 hours times	Į				1 . 1
	24 hours from 04/28/2	008 through 04/29/2008.					
-	The review revealed II	he pulse ox was scheduled					
	at 0000, 0600, 1200 a	nd 1800. The review					
	revealed the pulse ox	was not completed on					
	04/29/2008 at 1200. F		1				
	tevested no document	tation why the pulse ox was	Ė		1		1
Í		red and no evidence the		- 1			
	physician was notified	•		1			1
	A digital video recordir	to from the hospital's					
	security cameras date	d 04/28/2008 through					
	04/29/2008 was review	ved. The visico was	ĺ	1			1
1	recorded from Ward 3	West on the U2 unit and					1
	reviewed as recorded	time on 04/28/2008 at 2016		- 1]
	through 04/29/2008 at	2127.		1			
1	Review of the video re	vealed on 04/28/2008 at		1			
	2016 HCT #2 administ	ered medication to Patient	1	- 1			1 1
	#1. The video reveale	d the patient choked after		j			1 1
1	receiving the medication	in and fell backward hitting		- 1] [
	his head on the floor.	The video revealed HCT #2		- 1] [
	was performing abdom	inal thrusts on the patient		. 1			
1	while the patient was o	n the floor. The video		- 1			
	revealed LPN #1 laiked	to assist the HCT during		- 1			i i
Į.	the emergency situation	n. The video revealed no		j	•]
- 1	assessment of the pati	ent after the choking		- 1			i 1
	opisode and fall. Furth	er review of the video					
1	revealed Patient #1 wa	s assisted by two HCTs					
1	from the medication rec	om at 2019. The video					1 i
1	revealed the patient wa	s standing in the dayroom		- 1			
ĺ	at 2222 when HCT #21	took the patient's vital					1
1	signs. The video revea	iled Patient #1 set in a		- 1			
1	chair in the dayroom at	2225. The review					
1	revealed HCT #1 provid	ded the patient with a cup					l Ì
1	of liquid at 2238 and the	s patient was observed to		- 1			
- 1		·		ş			i f

	of deficiencies Correction	(X1) PROMOERISUPPLIERICHA IDENTIFICATION NUMBER:	(X2) MXR, YPPL A, BURLDING	E CONSTRUCTION	(X3) DATE SUPT COMPLETE		
					c	:	
	:	344003	B. WING	·····	08/69	2008	
name of Pr Cherry I	ovider or supplier Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 201 STEVENS MILL ROAD GOLDSBORO, NC 27530				
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencies y must be preceded by full .SC identifying information)	PRÉFIX PRÉFIX TAG :	PROVIDER'S PLAN OF CORRECTI (BACH CORRECTIVE ACTION SHOUL GROSS-REFERENCED TO THE APPRO DEFICIENCY).	CONSCRICTION CONSCRICTION CALL		
A 395	drink the liquid through the video revealed the same chair in the day 2059 (22 hours and 3 video revealed no flui patient after 2238 on remained sitting in the hours and 22 minutes the patient's intake as reveal documentation and output flow sheet on 04/29/2008 that the fluid on the 1500 thro surveillance revealed receive any fluids dur revealed that the patient en the night shift on 04/29/2008 or evening. Further review of the were taken on 04/29/video revealed no fur while the patient remained as taken at this time were taken on 04/29/video revealed in the record revealed to take the patient remained as taken at this time were taken on 04/29/video revealed to take the patient remained as taken revealed to take the patient of the video revealed the video fevealed the video revealed h a straw. Further review of a patient remained in the room until 04/29/2008 at 4 minutes). Review of the da were offered to the 04/29/2008 while the patient ochair in the dayroom (21 without fluids). Review of ad output record failed to a of this intake on the intake. There is documentation e patient received 900 cc of ugh 2300 shift. Video that Patient #1 did not ing this shift. The video ant did not receive any fluids 04/28/2008, day shift on g shift on 04/29/2008. Video revealed vital signs a not documented in the view revealed vital signs and 1640. Review of the record revealed the igns on 04/29/2008 at 1543, evasted no offort was made tal signs at 1543. Review of the patient's vital signs were the patient's vital signs were that the patient's vital signs were that the patient's vital signs on 04/29/2008 at 1630. Infirmed that the vital signs of 04/29/2008 at 1630. Review of at the patient's vital signs of 04/29/2008 at 1630. Review of at the patient's vital signs of 04/29/2008 at 1630. Review of at the patient's vital signs of 04/29/2008 at 1630. Review of at the patient's vital signs of 04/29/2008 at 1630. Review of at the patient's vital signs of 04/29/2008 at 1630. Review of at the patient's vital signs of 04/29/2008 at 1630. Review of at the patient's vital signs of 04/29/2008 at 1630. Review of at the patient's vital signs of 04/29/2008 at 1630. Review of at the patient's vital signs of 04/29/2008 at 1630. Review of the review of the video of the review of the video of the review of the video of the review of the video of the vi	A 395					
	in the dayroom. Furt	her review of the video			į		

Tatement of depresences no plan of correction	(XI) PROVIDENSUPPLIENCUA IDENTIFICATION NUMBER:	1	(XX) MULTIPLE CONSTRUCTION A. BUNDING		(X3) DATE SURVEY COMPLETED	
	344003	o. Von	s		C 08/09/2008	
Yans of provider or supplier Cherry Hospital			STREET ADDRESS, CITY, STATE, ZIP CODE 701 STEVENS INLL ROAD GOLDSBORO, NC 27530			041Z(160
PREFIX {EACH DEFICIENCY:	ec identilang inlouwvion) iprei 6e bleceded ba lat iemeni ol delichencies	PREF TAG	x	Provider's Plan of Correcti (Each Corrective Action Shoul Cross referenced to the Appro Deficiency)	0.62	(NS) CC(APIETIDA DATE
racord review. Review a HCT attempted to off patient to eat breekfest patient to eat breekfest patient appeared to refi that HCTs bring food to the trays to sit on a cart patients to get their own the video revealed no sencouraged the patient O4/29/2008. Review of patient did not receive fand 34 minutes that he the dayroom. The review of patient of the patient of the patient of the patient of the patient was lifted to a stopatient was lifted to a stopatient appeared unstat pulled a chair over and if the chair. The video shipatient in the chair down being taken down like he had the was the man of O4/28/2008 when the nurse stated she was the more stated she was the more patient in the chair when the nurse stated she was the more performing the Heinhurse stated "I watched request help. I got glove stood there and freaked Heimlich maneuver now couldn't see well or tell if tall. He got better. He was patient or the patient of the couldn't see well or tell if tall.	nich is consistent with the of the video revealed that fer and encourage the ton 04/29/2008 and the use. The video revealed ays to the ward and allow the use of the ward and allow the use of the ward and allow the use of the ward and allow the use of the ward of the video revealed the food during the 22 hours remained in the chair in aw revealed on 04/29/2008 cached the patient and up from the front by the transition. The ble and one of the HCTs lowered the patient into ows two HCTs sliding the in the hall toward his vealed the crash can allow at 2105. It is 0930 with LPN #1 redication nurse on duty and patient choked. The anding behind the patient fell and HCT #2 milch maneuver. The her do it. I did not as See I freaked out. I out. I have not seen the tin over twenty years. I	A	39			

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO.	0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CHA DENTIFICATION NUMBER:	1	ULTIPA LO!NG	LE CONSTRUCTION .	COMPLETE	٥
		. 344063	8. W/	10 <u></u>		C 08/09/2008	
наме ог Ря	OVIDER OR SUPPLIER			STR	eet adoress, caty, state, zip coze		
CHERRY I	HOSPITAL				n Stevens Mill Road Oldsboro, NC 27530		
(X4) ID PREFIX TAG	REFIX DEACH DESIGNERCY MUST BE PRECEDED BY FULL		PRES	D PROVIDERS PLAN OF CORRECTION PREFIX (RACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		.ose ∫	(XS) CONFEETION DATE
A 395	report it to her. I wait later and reported it to She told me to do an came up later. I didn interview with the nurse stoled the order after the PA saw the nurse stoled it is the that the orders are as not aware if the order the med room." The that LPN #1 did not a received a report on about the patients from the distribution of me knowledge if patients issues would be reported that the distribution of me knowledge if patients issues would be reported that the evening shift on 04/2 she had seen Polion the dayroom upon be interview revealed the had reported that the medications were be assumed the RN knowledge in RN	urse) found out. I didn't ted until I went downstairs of the house supervisor), incident report. (PA#8) It talk with him." Further are revealed she had a for vital signs and pulse ox patient on 04/28/2008. The RN's responsibility to see arried out. She stated "I was as were carried out. I'm in Interview further revealed attend shift report and medication administration and the off going nurse. The hat the lead HCT oversees at trays and she had no aware eating and that those and trays and she had no aware eating and that those and to the RN. The PN #1 also worked the 9/2008. The nurse stated I #1 steeping in the chair in ar arrival to the ward. The e day shift medication nurse a patient was sedated and ling held. The nurse stated "I we about his status. I read also. He didn't talk to me. He	A	395			
	needed to do an inci-				10111111111111111111111111111111111111		

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				(m approve) 10. 0938-039	
STATEMENT AND PLAN O	OF DEPIDIENCIES F CORRECTION	(X1) PROMDER/SUPPLIER/CIA IDENTIFICATION NUMBER:	OX2) MUS. A. BUSLO.	tple construction ng	OCS) DATE S	(X3) DATE SURVEY COMPLETED	
		344003	E. VING		İ	C	
NAME OF A	POVIDER OR SUPPLIESS		I			09/2008	
CHERRY	HOSPITAL		3	imret address.city. State, za coi 201 Stevens Mill Road Goldsbord, NC 27630	Nž		
ing in	(EACH DIJFFCHENC	atement of deficiencies 4 must be preceded by full -SC edentifying information)	PREFIX TAG	PROVOER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	CHOULD BE SEARGORPAN BE	OCHPIERON OAVE	
**************************************	incloent report and no delay in notifying the is was supposed to cell telked with (the PA) a ewere the patient fell. I did what happened." Furname did not notify the choking incident or the revealed that the charthe new orders written LPN would have trans nurse stated "I didn't dives aware that he (Pachair, I did not talk with nurse stated that she was not administered that paties choking episods on Od PA #B was not available survey. Consequently, Patient receiving medication o subsequently fell. The failed to respond to the assess the patient after report the incident to trobarge nurse (RN) failed failed to report the incidetayed reporting the call down in a chair in the area) on Od/28/2008 at choking incident at 202 the same chair for 22 in the same chair for 22 in	ality (PA #B). There was a PA because I didn't know I him. I don't remember if I bout the incident. I was not I don't know if he was lift talk with (LPN #1) shout ther interview revealed the a house supervisor of the afil. The interview ge nurse was not aware of a by the PA and that the cribed the orders. The lo observations that day. I afient #1) was sitting in the him the entire shift." The relied on staff to report if	A 39				

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0938-0391
Statement of deficiencies (XX) providensupplier/oua And plan of correction (VX) toentification number		1,	fding Méaisf	e contruction	(X3) DATE SURVEY COMPLETED		
		344003	B. ANN			C 08/09/2608	
		344003	L	Y		08/08	3/2008
MANE OF PH	Konder or Supplier				et address, Chy, State, 20 code 1 stevens mill road		
CHERRY	HOSPITAL			ŧ .	OLDSBORO, NO 27639		
(x4) ID Prefix Tag	(EACH DEFICIENC	atement of deficiencies y must be preceded by full .SC Iventifying information)	O PREF TAC	ex [Provider's Plan of Correc (Each Corrector Action Sho Cross-referenced to the Appl Objection	ULO BE	çcsi Completion Date
A 395	Continued From page	ı 42) A	395			
A 397	shift on 04/28/2008, rehift on 04/29/2008 as 04/29/2008. Staff me physician's orders for failed to offer tolleting the 22 hours and 34 remained in the chair staff failed to assess, patient to prevent need 482.23(b)(5) PATIEN A registered nurse mof each patient to oth accordance with the	embers failed to follow fluids and vital signs and t, fluids and nutrition during minutes that the patient in the dayroom. Nursing supervise and monitor the glect. T CARE ASSIGMENTS ust assign the nursing care or nursing personnel in patient's needs and the tons and competence of the		397	-		
	Based on policy revir- Interviews, the hospi- delogate and monito- assure nutritional ne- The findings include: Review of the "Meati- effective March 2004 provided with adequi- per a regular schedu- RN (registered nurse- to the dietician is impersonnel shall mon- needs, record food in		7-7-7-1 - 1-1-				

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		MEDICANO SERVICES	······································		OM8.N	O. 0938-0391
ататемент Амо Рили О	of deficiencies Foorrection	(X1) PROVIDER/SUPPLIED/CHA IDENTIFICATION NUMBER:		CULTIFIE CONSTRUCTION LOING	(X9) DATE SI COMPLE	urvey Teo
		344003	B. WAN	16	08/	C 09/2008
	ROVIDER OR SUPPLIER HOSPITAL			Street Address, City, State, 20 201 Stevens Mill, Road Goldsboro, NC 27630		5 W 25 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5
(X4) H) PREFIX TAG	(EACH DEFICIENC	atement of deficiencies y must be preceded by full SC :dentifying impormation)	ID PREFI TAS	PROVIDER'S IN.A. PROVIDER'S IN.A. (EACH CORRECTIVE CROSS-RIPERENCED	FOF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE LENCY)	ONFLETION OATE
A 397	flow sheet by nursing meal/nourishment lim refused by a nursing treported to the charge Observation on 08/09 cafeteria revealed pat area with three staff in Observation revealed after eating and return	ented on the multi-purpose personnel at each aAny meet/nourishment actity petient shall be nurse." /2008 at 1210 of the U2 lents eating in the dining nembers present, patients covered their trays	Α.	397		
	staff member that was during the observation documented the meal the patients in the dini interview on 08/09/200 staff member that was during the observation	present in the dining room) revealed she had consumption for three of ng room. 38 at 1217 with HCT #4 (a present in the dining room) revealed she had consumption for four of the				
	staff member that was during the observation total patients eating in member was asked ab consumption for the pathe staff member state accountability today.	dients in the dining room. Id "I am deing	**************************************			
:	Interview on 08/09/200 edministrative staff me supposed to look at the the patients eat. The s there were a total of 14	mber revealed the staff are trays and document what taff member confirmed				

	O LOV INCOVAVE OF	MISCHUMID SERVICES					
	of deficiencies Correction	(X1) PROMDERSUPPLIERCLIA IOENTIFICATION HUMBER:	1' '	UKTIPET LOKING	e construction	COMPLETED COMPLETED	
		344003	8. WING			08/09/2008	
	ovider or supplier Tospital		Street address. City, State, 204 code 201 Stevens Mill Road Goldsbord, NC 27530				
(/4) (0 PREFIX TAG	(EACH DEFICIENC	Atement of deficiencies Y must be preceded by full LSC identifying impormation)	IO PREF TAG	i T	Provider's Plan of Correct Flan of Correct From SHC CROSS-REFERENCED TO THE APPROPRIESTON DEFICIENCY)	VLO 86	Ges) Goupelitien Date
A 397 A 405	confirmed that 7 of the have documentation	e 44 ° staff member see 14 patients (50%) did not of meal consumption. STRATION OF DRUGS		397 405			
	by, or under supervis personnel in accorda laws and regulations	cals must be administered tion of, nursing or other ince with Federal and State , including applicable its, and in accordance with all staff policies and		.,			
	Based on policy revidigital video recording the hospital failed to administered by licer sampled records (IFT The findings include: Review of the hospit Administration" policial administration policial record by regidicensed practical nu Services Department health care technicistered by the cart with for the purpose of processing around the who may be hostile:						

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	The state of the s	2011-01-01-01-01-01-01-01-01-01-01-01-01-				OM8 NO. 0938-039	
BYATEMENT OF DESICIENCIES AND PLAN OF CORRECTION		(X) PROMIERATOPPHENCIA IDENTIFICATION SUMBER:	1	CX) MATTPLE CONSTRUCTION A. STALDAGS		(X3) DATE SURVEY COMPLETED	
		344003		43		C 08/09/2008	
name of provicer or supplier Cherry Hospital				2	reet address, city, state, zip gode 201 Stevenb Mill Road 30LDSBORO, NC 27636	1) P12000
(X4) ID PREF/X TAG) (Each ()epic/enc	Atement of Deficiencies Y must be precided by full SC identifying information	ID PREF TAG	ix	PROVIDER'S MAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-RIPERENCED TO THE APPR DEFICIENCY)	PLAN OF CORRECTION THVE ACTION SHOULD BE ICED TO THE APPROPRIATE	
**************************************	and/or obtaining vital policy revealed that the certified in medication administering medical Paleon (MAR) revealed were administered on #1. Review of a nursi 04/28/2008 at 2020 do was taking his po (orachoking. Heimilich mapatiant was assisted o was able to stand up a bed. Pt. was broathing Review of a digital vidit patient entered the interest of the fell backward floor after he began chrevealed inch began apatient after he fell to the interview on 08/08/200 revealed HCT #2 administered the HCT #2 administered HCT #2 administered HCT #2 administered HCT #2 administered HCT #2 administered HCT #2 administered HCT #2 administered HCT #2 administered HCT #2 administered HCT #2 administered HCT #2 administered HCT #2 administered HCT #2 administered HCT #2 administered HCT should the patients. The staff meredication out. I had called him. The medicine and gave	signs. Further review of the re RNs and LPNs must be administration prior to tions. of Patient #1 revealed (1) of Patient #1 revealed (1) of Patient #1 revealed (1) of Patient #1 revealed (1) of Patient #1 revealed (1) of Patient #1 revealed (1) of Patient #1 revealed (1) of Patient #1 revealed (1) of Patient #1 revealed (1) of Patient PN #1 dated (1) ocumented "PL (patient) of meds and started (1) neds and started (1) neds and started (1) neds and started (1) or recording revealed the priview room on 04/28/2008 ication. The video revealed red the medication. The patient began to cough, hitting his head on the oking. The video review bdominal thrusts on the he floor. 6 at 0930 with LPN #1 instered the medication to	A	405	1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PROVIDER CHI SUPPLIER CHERRY HOSPITAL CHERY	CENTER	S FOR MEDICARE &	MEDICAIO SERVICES				OMB NO	2. 0938-0391		
A 405 Continued From page 46 past that she had done that and they just laughed at mo. No, I didn't tell the nurse about her giving the medication. I don't know if the charge nurse (RN) was aware of her giving meds." Interview with HCT #2 was attempted. The staff member was not available for interview. Interview on 08/09/2008 at 1020 with RN #2				1		CONSTRUCTION		COMPLETED		
CHERRY HOSPITAL. 201 STEVENS MILL ROAD GOLDSBORO, NC 27539 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH CONRECTIVE ACTION SKOULD BE COMPLETED TO THE APPROPRIATE CATE REGULATORY OR LSC IDENTIFYING INFORMATION) A 405 Continued From page 46 past that she had done that and they just laughed at rne. No, I dign't tell the nurse about her giving the medication. I don't know if the charge nurse (RN) was aware of her giving meds." Interview with HCT #2 was attempted. The staff member was not available for interview. Interview on 08/08/2008 at 1020 with RN #2			344003			**************************************	E			
REGULATORY OR LISC IDENTIFYING IMPORAMTION) A 405 Continued From page 46 past that she had done that and they just laughed at me. No. I didn't tell the nurse about her giving the medication. I don't know if the charge nurse (RN) was aware of her giving meds." Interview with HCT #2 was attempted. The staff member was not available for interview. Interview on 08/08/2008 at 1020 with RN #2		,			STREET ADDRESS, CITY, STATE, 2IP CODE 201 STEVENS MILL ROAD					
past that she had done that and they just laughed at me.' No, I didn't tell the nurse about her giving the medication. I don't know if the charge nurse (RN) was aware of her giving meds." Interview with HCT #2 was attempted. The staff mamber was not available for interview. Interview on 08/08/2008 at 1020 with RN #2	户数数约次	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY PULL			(Each Corrective action Cross-referenced to the	SHOULDEE	COMPLETION COMPLETION		
the 1500 - 2300 shift on 04/28/2008. The nurse stated that who had not been made aware that HCT #1 administered the medication to Patient #1 on 04/28/2008. The interview revealed that the HCT should not have administered the medication.	A 405	past that she had dor at me." No, I didn't let the medication. I dor (RN) was aware of he Interview with HCT # member was not ava Interview on 08/08/2(revealed she was the 1500 - 2300 shift stated that she had n HCT #1 administered #1 on 04/28/2008. The HCT should not he	ne that and they just laughed If the nurse about her giving I'l know if the charge nurse or giving meds." 2 was attempted. The staff illable for interview. 108 at 1020 with RN #2 or charge nurse on duty during on 04/28/2008. The nurse of been made aware that If the medication to Patlent he interview rovealed that	A	405					